

Envoy Medical Systems, LP
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IRO Certificate #4599

DATE OF REVIEW: 11/20/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RT L4-L5 Transforaminal Epidural Steroid Injection (ESI) w/fluoro (CPT: 64483, 77003, 99144)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Anesthesiology & Pain Management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)	<u>X</u>
Overtaken	(Disagree)	
Partially Overtaken	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant, a XX year old female, fell off a stool in XX/XXXX, resulting in low back and right leg pain. An MRI on 4/20/15 was reported to show a focal right L4-L5 3mm protrusion with no foraminal nor canal stenosis. Also a left L5-S1 3mm protrusion with no canal nor foraminal stenosis. Physical therapy and medications were applied. She was referred to XX for evaluation. There was no neurological deficit found upon physical examination. An epidural steroid injection was ordered.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: I agree with previous reviewers that there is no objective documentation of radiculopathy. Since the last denial electrodiagnostic studies were performed that were normal. There is no deficit on physical exam and no impingement on MRI. ODG for epidural steroid injections require evidence of radiculopathy. There should be objective findings in corroboration with imaging studies and/or electrodiagnostic testing. These criteria are not met.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)